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Office of Administrative Law Judges
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Issue Date: 28 July 2003

Case No. 1999-BLA-357

In the Matter of:
RUTH ENDICOTT, WIDOW OF
AUXIER ENDICOTT,
Claimant,

v.

MARTIKI COAL COMPANY,
Employer,
and
MAPCO, INC.,
Carrier,

and
DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:
Stephen A. Sanders, Esq.
On behalf of Claimant

W. William Prochot, Esq.
On behalf of Employer/Carrier

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

THIRD DECISION AND ORDER ON REMAND - DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the

Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

Procedural History

Auxier Endicott ("Miner") filed his first application for benefits under the Act on December 10, 1985. (DX 53-135). A Deputy Commissioner from the Office of Workers' Compensation Programs ("OWCP") issued an order to show cause abandonment of claim/denial on March 13, 1986. (DX 53-111). After Miner failed to respond, the OWCP issued correspondence to counsel for Employer stating that Miner's application for benefits was deemed to be abandoned and closed. (DX 53-107). Counsel for Miner submitted medical evidence and requested that Miner's case be reopened on October 7, 1987. (DX 53-98). The OWCP stated that Miner's application remained denied by abandonment, and added that Miner must file a new claim to receive and further consideration. (DX 53-97). The next document in the record is the OWCP's July 5, 1988 proposed decision and order of no material change in conditions and denial of claim in accordance with *Lukman v. Director, OWCP*. (DX 53-93). On March 30, 1990, the Board remanded Miner's application for benefits to the Office of the Administrative Law Judges in light of *Lukman v. Director, OWCP*. (DX 53-88). Following a formal hearing, Administrative Law Judge Peter McCann Giesey issued a decision and order denying benefits on April 2, 1992. (DX 53-37). Administrative Law Judge Giesey found the existence of coal workers' pneumoconiosis after applying the since dispensed "true doubt" rule. However, Administrative Law Judge Giesey denied benefits after he found that the record contained no evidence upon which to base a finding that Miner is totally disabled due to pneumoconiosis. On September 20, 1993, the Board affirmed the denial of benefits on the grounds that the evidence failed to establish total disability due to pneumoconiosis. The Board did not address Employer's contention on appeal that the x-ray evidence did not establish coal workers' pneumoconiosis, nor did the Board address Administrative Law Judge Giesey's failure to consider whether a material change in conditions was established. (DX 53-1).

Miner filed a second duplicate claim for benefits on June 30, 1995. (DX 1). Following two proposed decisions and orders denying benefits that were issued by the OWCP, Miner's second duplicate claim for benefits came before the Office of the Administrative Law Judges for a formal hearing. Miner died on February 6, 1998. Accordingly, on March 2, 1998, Administrative Law Judge Daniel Roketenetz remanded Miner's claim in order for it to be consolidated with a survivor's claim to be filed by his widow, Ruth Endicott ("Claimant"), as well as to allow additional evidentiary development. Claimant filed an application for survivor's benefits on May 8, 1998. She attached a notarized affidavit to her application for survivor's benefits indicating her

[1]The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

intent to pursue Miner's application for living miner's benefits. On September 3, 1998, a claims examiner for the OWCP denied both the survivor's claim and the living miner's claim. Claimant appealed and requested a formal hearing, which was held before the undersigned on May 19, 1999.

On August 19, 1999, I issued a decision and order award of benefits for miner and survivor.[2] I analyzed the living miner's claim as a modification request of a duplicate claim. I found that the x-ray evidence continued to support a finding of pneumoconiosis arising out of coal mine employment. I also found that a material change in conditions after finding that the evidence established the existence of total disability due to pneumoconiosis. On appeal, the Board issued a decision and order affirming in part and vacating in part my decision and order award of benefits for miner and survivor. The Board affirmed as unchallenged on appeal my determination of Miner's length of coal mine employment and that Miner was totally disabled under the former § 718.204(c). The Board vacated my finding that the x-ray evidence established the existence of pneumoconiosis, and accordingly, the Board also vacated my findings of pneumoconiosis arising out of coal mine employment, total disability due to pneumoconiosis, and death due to pneumoconiosis. In an unnumbered footnote at the end of the decision and order, the Board stated, "[w]e note, however, that the miner's claim is subject to automatic denial unless claimant establishes a material change in condition since the previous denial of benefits."

I issued a decision and order on remand awarding benefits for miner and survivor on October 5, 2001. Employer again sought review before the Board. The Board issued a decision and order on November 26, 2002, vacating my decision and order on remand awarding benefits to miner and survivor. The Board remanded the claim for further consideration of the evidence at § 718.202(a), § 718.204(c), and § 718.205(c). Again, the Board affirmed as unchallenged on appeal my determination of the length of Claimant's coal mine employment and that Miner was totally disabled under the provision now found at § 718.204(b). Administrative Appeals Judge Regina McGranery issued a separate decision, concurring in part and dissenting in part. Administrative Appeals Judge McGranery's dissent focused on the Board's review of my treatment of Dr. Sundaram's opinion, arguing that the Board should have affirmed my determination to credit Dr. Sundaram's opinion over those of consulting physicians. Administrative Appeals Judge McGranery also argued that the Board should affirm my construction of Dr. Sundaram's opinion as a proper exercise of discretion. Thus, the issues remaining for adjudication are whether Claimant has established the existence of pneumoconiosis, whether Miner's total disability prior to death was due to pneumoconiosis, and whether Miner's death was due to pneumoconiosis.

On February 13, 2003, I issued an order allowing briefs on remand. Counsel for Claimant and Employer filed briefs on remand, and the District Director declined to file a brief. Based

[2]At the hearing, Employer withdrew as contested issues whether the claims were timely filed, whether Miner engaged in coal mine employment after December 31, 1969, whether Ruth Endicott was a dependent, and whether Martiki Coal Corporation was the appropriate responsible operator. Additionally, the parties stipulated that Miner engaged in coal mine employment for 10 years.

upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

MEDICAL EVIDENCE

I incorporate by reference, as if fully rewritten herein, all chest x-rays, pulmonary function tests, arterial blood gas studies, narrative medical opinions, hospital records, treatment records, and all other medical evidence contained in the undersigned's decision and order dated August 19, 1999 to the extent that it is not inconsistent with the medical evidence reviewed herein.

DISCUSSION AND APPLICABLE LAW

Living Miner's Claim

Duplicate Claim

Miner filed a duplicate claim for benefits on June 30, 1995, which was more than one year after the Board affirmed Administrative Law Judge Giesey's decision and order denying benefits. The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Compamy*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). Section 725.309(d) provides that:

> If the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the deputy commissioner determines that there has been a material change in conditions or the later claim is a request for modification and the requirements of § 725.310 are met.

The Benefits Review Board defined "material change in conditions" under § 725.309(d) as occurring when a claimant establishes, by a preponderance of the evidence developed subsequent to the prior denial, at least one of the elements of entitlement previously adjudicated against the claimant. *See Allen v. Mead Corp.*, 22 B.L.R. 1-61 (2000). The Board has also held that a material change in conditions may only be based upon an element which was previously denied. *Caudill v. Arch of Kentucky, Inc.*, 22 B.L.R. 1-97 (2000) (en banc on recon.) (where Administrative Law Judge found that claimant did not establish pneumoconiosis and did not specifically address total disability, the issue of total disability may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions). Lay testimony alone is insufficient to establish a material change in conditions. *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122 (1999).

This matter arises under the jurisdiction of the Sixth Circuit Court of Appeals.[3] In *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001), the Sixth Circuit held that, under *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), it is insufficient for the ALJ to merely analyze the newly submitted evidence to determine whether an element previously adjudicated against the claimant has been established. An administrative law judge must also compare the sum of the newly submitted evidence against the sum of the previously submitted evidence to determine whether the new evidence is substantially more supportive of claimant. *Kirk*, 264 F.3d at 609.

Administrative Law Judge Giesey denied Miner's prior application for benefits after finding the existence of pneumoconiosis arising out of coal mine employment, because he found that there is no evidence to support a finding of total disability due to pneumoconiosis. Since the element of pneumoconiosis was not decided against Miner in the prior denial of benefits, Claimant cannot establish a material change in conditions by establishing the existence of pneumoconiosis.[4] In the present duplicate claim, the parties have stipulated that Miner was totally disabled due to a pulmonary or respiratory impairment; an element that was previously adjudicated against Miner. The medical opinions considered by Administrative Law Judge Giesey regarding total disability all tended to show that Miner retained the respiratory capacity to perform his usual coal mine employment.[5] The medical evidence developed after the denial of Miner's previous claim, including the opinions of Drs. Branscomb, Broudy, Caruso, Fino, Sundaram, and Younes, strongly supports a finding of a totally disabling respiratory or pulmonary impairment and shows a worsening of Miner's physical condition prior to death. Accordingly, I find that Claimant has established a material change in conditions in the living miner's claim for benefits since the prior denial of the living miner's claim. Therefore, I will review the entire evidentiary record *de novo* to determine if Claimant is entitled to living miner's benefits.

Miner's claim for living miner benefits was filed after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, the following elements:

1. That Miner suffered from pneumoconiosis;

2. That his pneumoconiosis arose, at least in part, out of coal mine employment;

3. That he was totally disabled prior to his death; and

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[3]Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc). Miner last engaged in coal mine employment in Kentucky.

[4]Since Administrative Law Judge Giesey employed the "true doubt" rule to find the existence of pneumoconisois, and also because the Board did not rule on the issue on appeal, Claimant must still establish the existence of pneumoconiosis.

[5]Although Administrative Law Judge Giesey issued his opinion in 1992, the most recent medical evidence that he considered was from 1988.

4. That his total disability was caused by pneumoconiosis.

See §§ 719.3, 718.202, 718.203, 718.204; *Gee v. W.G. Moore*, 9 B.L.R. 1-4, 1-5 (1986); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-212 (1985). Failure to establish any of these elements precludes entitlement. *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987). Claimant has already established the Miner was totally disabled at the time of his death due to a respiratory impairment.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
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> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
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> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The record consists of 41 interpretations of 23 x-rays spanning from August 1987 until the day before Miner's death on April 5, 1998. Of the 41 interpretations, only 24 were properly classified in accordance with the quality standards contained at § 718.102 and Appendix A to Part 718. The remaining 17 interpretations were not read for the purpose of diagnosing the presence

of absence of pneumoconiosis. For x-ray interpretations that are not classified in the ILO format and do not mention pneumoconiosis, an administrative law judge has discretion to infer whether or not the x-ray is negative for pneumoconiosis. *See Billings v. Harlan #4 Coal Co.*, BRB No. 94-3724 BLA (June 17, 1997)(en banc)(unpublished). Upon review of the unclassified x-ray interpretations, the undersigned could not infer that any of the 17 unclassified x-ray interpretations were negative

Dr. Ellis, who is a board-certified radiologist, found an x-ray dated August 27, 1987 to be negative. There were no other interpretations of this film. I find that the August 27, 1987 film is negative. Drs. Poulos, Spitz, and Wiot all offered negative interpretations of a film dated September 22, 1987. There were no other interpretations of this film. I find that the September 22, 1987 film is negative. I also find that the November 23, 1987 film is negative, based on the uncontradicted negative interpretations of Drs. Halbert, Reddy, and Wiot. A February 26, 1988 film was interpreted by Dr. Broudy as negative. As his interpretation was the only one, I find that the February 26, 1988 film is negative. Drs. Scott and Wheeler, who are dually-certified radiologists and B-readers interpreted a film dated August 9, 1991 as negative. Dr. Myers and Dr. Baker, who is a B-reader, found the same film to be positive. It is appropriate to credit the interpretation of a dually-certified physician over the interpretation of a B-reader. *See Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999)(en banc on recon.). I attribute greater weight to the interpretations of Drs. Scott and Wheeler based on the credentials, and find that the August 9, 1991 film is negative.

There are 9 x-rays from 1994 that cannot support a finding of pneumoconiosis by x-ray evidence under § 718.202(a)(1), since they are not properly classified in accordance with the quality standards of Part 718, nor can I infer whether they are establish the presence or absence of pneumoconiosis. Dr. Sargeant interpreted a film dated April 11, 1995 as negative. Two other physicians, both of whom are board-certified radiologists, found the film to reveal chronic pulmonary disease. Since it is not possible to infer whether their opinion finds the presence or absence of pneumoconiosis, and the only other interpretation is negative, I find that the April 11, 1995 x-ray is negative. Dr. Barrett, who is a dually-certified physician, and Dr. Younes, who is a B-reader, found a July 21, 1995 x-ray to be positive. In contrast, Drs. Sargeant, Wheeler, Scott, Spitz, and Wiot, all of whom are dually-certified physicians, found the film to be negative. Also, Dr. Goldstein, who is a B-reader, found the x-ray to be unreadable. The more numerous interpretations offered by 5 dually-certified physicians establishes by a preponderance of the evidence that the July 21, 1995 x-ray is negative. Drs. Pruitt, Sargeant, and Fino found that the film dated July 29, 1995 was negative. There are no contradictory opinions. Therefore, I find that the July 29, 1995 x-ray was negative.

Dr. Broudy interpreted a film dated September 1, 1995 as negative, and no other interpretation was rendered. I find that the September 1, 1995 x-ray was negative. I cannot infer whether Dr. White's interpretation of an August 5, 1996 reveals the presence or absence of pneumoconiosis, thus it cannot establish the existence of pneumoconiosis. Similarly, I cannot infer whether the films dated January 29, 1998 and February 5, 1998 reveal the presence or absence of pneumoconiosis.

Of the 24 properly classified x-ray interpretations of nine x-rays, only four were positive. After analyzing the interpretations of all 9 x-rays that were the subject of properly classified interpretations, I determined that all nine x-rays were negative for the existence of pneumoconiosis. I could not infer whether the non-classified x-rays established the presence or absence of pneumoconiosis. As such, I find that Claimant has not established the existence of pneumoconiosis by a preponderance of the x-ray evidence under § 718.202(a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based upon biopsy evidence for living miners and autopsy evidence for deceased miners. Miner underwent several biopsies, but no autopsy was performed after his death.

On April 29, 1994, Raghu Sundaram performed a bronchoscopy and bronchial lavage and brush. Sputum obtained was negative for malignant cells. There were no myobacteria or tuberculosis organisms identified. A little bit of inflammation with friable mucosa was noted. In his discharge summary, after reviewing the results of Dr. Sundaram's bronchoscopy, Dr. Caruso opined that the findings would suggest an infection origin with tuberculosis to be excluded. Dr. Caruso ordered more invasive testing and an infectious disease consultation with Drs. Rogers, Earle, and Saha at Central Baptist Hospital.

Dr. Whaley conducted a CT guided needle biopsy of the right upper lobe on May 5, 1994. His impression included a finding of extensive nodular cavitary infiltrate in the right upper lung with volume loss and pleural thickening. He also observed less extensive infiltrate and pleural thickening in the left upper lung, with some minimal patchy nodularity and pleural thickening elsewhere in both lungs. Dr. Whaley also identified the presence of obstructive airways disease, which he would favor as a granulomatous process and infectious process. He opined that the cavitary right infiltrate could be secondarily involved with fungal disease. He wanted to compare his impression with prior x-rays. A pathology report prepared by Marian Bensema, M.D. on May 6, 1994 from the biopsy samples, diagnoses inflammatory debris, the absence of a tumor, and states stains for acid fast bacilli are negative. Dr. Bensema provided a microscopic description of the biopsy specimen. She identified inflammatory cells trapped in fibrin, the absence of granulomas, and no malignancy.

Dr. Saha performed a flexible fiberoptic bronchoscopy on May 6, 1994 with washings. Upon discharging Miner from Lexington Central Baptist Hospital on May 11, 1994, Gary Earle, M.D. commented that the bronchoscopy showed some friability in the right upper lobe bronchus, but biopsies and washings were negative for tumor or infectious agents, such as tuberculosis or histoplasmosis. Dr. Earle also noted that Miner had a negative skin tuberculosis test. On discharge, Dr. Earle diagnosed: 1). chronic obstructive airways disease ("COPD") with bilateral cavitary pulmonary infiltrates; 2). possible tuberculosis although no acid fast bacilli studies were positive; and 3). possible chronic histoplasmosis.

Dr. Rogers evaluated Miner for bilateral pulmonary cavitary infiltrates while Miner was hospitalized in May of 1994. He concluded that the bilateral cavitary pulmonary infiltrates are indications of tuberculosis or histoplasmosis. On June 2, 1994, Dr. Melo examined Miner and determined that Miner may have tuberculosis or histoplasmosis.

Roy Bowling, M.D. performed a flexible bronchoscopy on July 20, 1994. His preoperative diagnosis was "essentially destroyed right upper lobe with marked scarring and volume loss; several areas of infiltrative densities present in the left lung of questionable etiology." Lawrence Boram, M.D. analyzed the bronchial brushings and washings obtained by Dr. Bowling. Dr. Boram determined that the bronchial brushings from the right and left lungs were negative for malignant cells. He also determined that the bronchial washings revealed a cluster of atypical reactive bronchial cells, as well as the presence of rare candida spores. Carolin Burns, M.D. evaluated a left upper lobe lung biopsy specimen on July 21, 1994 that was obtained on July 20, 1994. Dr. Burns' impression was mild chronic active inflammation and fibroplasia in disrupted respiratory mucosa, as well as rare minute fragments of benign respiratory epithelium-nondiagnostic. She commented that the second specimen she analyzed was "quite scanty." In the specimens, Dr. Burns did not detect granulomas. She did find some fibrinohemorrhagic material interspersed between the tissue pieces. Apparently the specimens were sent to the Jewish Hospital Pathology Laboratory, which provided microbiology reports on the lung specimens on September 3, 1994. Brushings from the right and left upper lobes did not reveal acid fast bacili, nor did the lung washings. The lung washings contained few yeast, and three types of fungus: candida tropicalis, candida krusei, and aspergillus species. Other cultures revealed moderate respiratory flora and no fungal elements.

Dr. Sundaram examined Miner on August 5, 1996 at the Highlands Regional Medical Center and found that Miner had persistent pneumonic consolidation changes over the right upper lobe. Considering Miner's weight loss, Dr. Sundaram primarily considered tuberculosis. However, Miner could not cough up a sufficient sample. So, Dr. Sundaram scheduled Miner for a bronchoscopy the following day to rule out the presence of an endobronchial lesion, besides satisfactory sampling to test for tuberculosis. Prior to performing the operation, Dr. Sundaram considered differential diagnoses of malignancy, tuberculosis, and fungal infections. On August 6, 1996, Dr. Sundaram performed a lung biopsy of Miner's right upper lobe. He completed an operative report describing the bronchoscopy he performed. In passing the bronchoscope into Miner's lungs, Dr. Sundaram detected a fleshy nodule lesion at the entrance of the right upper lobe, from which he obtained lavage and brushings. His final diagnosis was aspergillus infection. In his pathology report, Dr. Sundaram commented that the specimen contains multiple fragments of necrotic material and non-septate parallel hyphae, which are findings of Aspergillus infection. Upon discharging Miner on August 8, 1996, Dr. Caruso noted Dr. Sundaram's finding from the bronchoscopy that Miner suffered from a pulmonary aspergillosis infection. Dr. Caruso prescribed Sporanox for long-term control of Miner's aspergillosis and Miner's cavitary lung disease. In his discharge diagnosis, Dr. Caruso's first diagnosis was pulmonary aspergillosis and his second diagnosis was coal workers' pneumoconiosis with cavitary lung disease. Upon admission to the hospital, Dr. Caruso sought to rule out coal workers' pneumoconiosis, emphysema, and a return of infection in underlying cavitary lung disease due to Miner's worsening hemoptysis and lung symptomatology.

Employer submitted the consultative reports of several physicians who summarized and commented on the biopsy evidence. On October 13, 1997, Ben Branscomb, M.D. reviewed Miner's medical records and issued a consultative report. Dr. Branscomb opined that Miner has

no simple or complicated pneumoconiosis. He summarized the findings of the various biopsy and bronchoscopy reports. However, Dr. Branscomb did not offer a specific opinion on the biopsy or bronchoscopy evidence.

Gregory Fino, M.D. examined Miner's medical records and issued a consultative report on October 22, 1997. He reviewed the results of the biopsy that Miner underwent while hospitalized in May of 1994. Dr. Fino offered that the finding of obstructive lung disease with bilateral upper lobe cavitary infiltrates would suggest a possible fungus or tuberculosis. Even thought Dr. Fino apparently reviewed the other biopsy reports, he did not offer his opinion on the findings. He did opine that there is insufficient objective medical evidence to justify the diagnosis of simple CWP. Dr. Fino also found that Miner had an Aspergillus infection of the lungs.

Raphael Caffrey, M.D., who is board-certified in clinical and anatomical patholog,y issued a supplemental consultative report October 30, 1997. He reviewed Miner's medical records, including a pathology report dated August 6, 1996. He also reviewed four surgical pathology slides that are not dated, nor do they contain a patient's name. The slides were presented to Dr. Caffrey as the result of result biopsies of Miner's right upper lung lobe. He identified the presence of fungus organisms. Dr. Caffrey did not find any macules, anthracotic pigment, nor fibrosis. He diagnosed acute inflammation with necrosis, and fungus organisms consistent with Aspergillus infection. Dr. Caffrey also concluded that there are no findings of CWP identified in the biopsy material. He noted that physicians often suspected tuberculosis or histoplasmosis. Since neither of these could be confirmed, Dr. Caffrey suggested that Miner all along had chronic progressive and destructive pulmonary disease, most likely due to Aspergillus. Dr. Caffrey disputed Dr. Younes diagnosis of Caplan's syndrome because none of the radiologists have described the changes of Caplan's syndrome in the chest x-rays. He concluded that the biopsy evidence confirms that Miner had pulmonary Aspergillosis, which was not related to his coal mine employment. Dr. Caffrey could not make a diagnosis of CWP or any other occupational pneumoconiosis based on his review of Miner's medical records and biopsy slides.

Dr. Caruso admitted Miner to the Highlands Regional Medical Center on January 29, 1998, and Dr. Sundaram performed a consultative examination on January 30, 1998. Dr. Sundaram performed a bronchoscopy and biopsy of Miner's right and left upper lobes. Following the procedure, Dr. Boswell produced a surgical pathology report, wherein he diagnosed hemorrhage, necrosis, acute inflammation, and atypical bronchial epithelium with in both the left and right lobe. John Meredith, M.D. issued three separate pathology consultation reports after analyzing three bronchial lavage samples. In all three reports issued on February 3, 1998, Dr. Meredith did not identify any malignant or atypical cells. C.T. Anderson, M.D. issued a pathological consultative report on February 4, 1998 after analyzing a sample of Miner's sputum. Dr. Anderson found that the sample was mostly saliva, and that it was negative for malignant cells. In a summary dictated on February 5, 1998, with the intent of discharging Miner that day, Dr. Caruso stated that the cultures obtained by Dr. Sundaram's were positive for Pseudomonas aeruginosa. Dr. Caruso also noted that at the time of discharge, studies for tuberculosis and cancer were pending, but so far none had been positive. Due to Miner's condition, Dr. Caruso was unable to discharge him and he died on February 6, 1998. Dr. Caruso then dictated an expiration report on February 6, 1998, noting that the only findings from the biopsy were sputum culture of Pseudomonas aerogenous.

On January 30, 1998, Dr. Branscomb submitted his third consultative opinion. In his five-line report, he stated that he reviewed the consultative report of Dr. Caffrey dated October 29, 1997. Dr. Branscomb found that Dr. Caffrey's pathology and opinions confirm his own opinions dated October 13, 1997 and October 30, 1997.

Dr. Caffrey submitted a supplemental consultation report on April 28, 1999. He reviewed additional biopsy slides and cytology reports, as well as additional hospital records. In his review of the slides, he did not identify any anthracotic pigment, but he did see multiple organisms consistent with Aspergillus infection. From the slides, Dr. Caffrey diagnosed multiple Aspergillus organisms, and acute inflammation with necrosis and hemorrhage. Dr. Caffrey stated that it was still his opinion that he could not render a diagnosis of CWP. He noted that final expiration summary from Highlands Regional Medical Center, and concluded that none of Miner's pulmonary problems were related to his coal mine employment. Dr. Caffrey opined that Miner's rheumatoid disease, Caplan's syndrome, Pseudomonas pneumonia, and pulmonary aspergillosis were definitely not caused by coal mine employment. He added that Caplan's syndrome is the result of rheumatoid disease, and that Miner's significant smoking history certainly caused some of Miner's pulmonary problems.

On May 2, 1999, Dr. Branscomb issued a fourth consultative opinion after he reviewed additional medical records. He stated that the additional evidence merely repeats Miner's well-documented history of chronic rheumatoid arthritis with severe gastrointestinal problems, as well as an apical process with pleural involvement, scarring, cavitation, and proved aspergillus infection. Dr. Branscomb asserted that the additional medical evidence he reviewed contained no new information to attribute any pulmonary disease to coal dust exposure, although Dr. Caruso continues to list Caplan's syndrome. Dr. Branscomb opined that there is no reasonable basis for diagnosis Caplan's syndrome because the x-rays do not support such a diagnosis. Rather, he found Miner's x-rays to be typical of a granulomatous disease.

Dr. Caffrey was deposed on May 7, 1999. When questioned about his reports dated October 30, 1997 and April 28, 1999, Dr. Caffrey stated that his review in those reports of Miner's biopsy slides showed that there was no evidence of CWP. Dr. Caffrey found that his pathological findings were substantiated by his review of Miner's medical records. Dr. Caffrey stated that his review of the biopsy slides showed acute inflammation with necrosis and infection due to Aspergillus organisms, which he stated was not that uncommon in individuals who lost their immunity like Miner did because of the treatment Miner underwent for rheumatoid arthritis. He also commented that the slides showed severe infection with Aspergillus organisms.

Dr. Fino submitted a supplemental consultative report on May 9, 1999 after reviewing additional medical evidence containing pathology information regarding the biopsies of Miner's lungs. He found that there was no evidence of Caplan's syndrome, which is due to rheumatoid arthritis. Dr. Fino stated that Miner had very significant lung infections due to bacteria (Pseudomonas) as well as fungus (Aspergillus). He noted that the bacterial and fungal infections were diseases of the general population that are not related to coal mine employment.

Dr. Caruso issued a hand-written opinion on May 13, 1999. He noted that he treated Miner from 1994 through Miner's demise in 1998. Dr. Caruso stated that he treated Miner for

the four year period for anthracosilicosis (black lung), rheumatoid disease, and (sic) Kaplan's syndrome, a cavitary nodular lung disease caused by concomitant pneumoconiosis and rheumatoid disease.

On May 18, 1999, Jerome Kleinerman, M.D., who is board-certified in clinical and anatomical pathology, issued a consultative report after reviewing Miner's medial records and histological slides. He considered a coal mine employment history of 10-12 years with a smoking history of one pack per day for 37 years tapering to several cigarettes per day. He found that Miner's medical history was remarkable for severe rheumatoid arthritis, peptic ulcer disease, chronic anemia, and Caplan's syndrome. He also noted that Miner was treated for cavitary lung disease, tuberculosis, histoplasmosis, and pulmonary Aspergillus. Dr. Kleinerman summarized Miner's medical evidence, including a pathological review of the biopsy slides. He opined, based on his review of the medical records as well as the histological slides, that Miner has no objective evidence of CWP.

Dr. Fino discussed a letter authored by Dr. Caruso on May 13, 1999 in a letter addressed to counsel for Employer on June 14, 1999. Dr. Fino noted that Dr. Caruso diagnosed black lung, rheumatoid disease, and Caplan's syndrome caused by rheumatoid arthritis and concomitant pneumoconiosis. Dr. Fino stated that Dr. Caruso provided no valid, objective evidence to support his conclusions. He added that Dr. Caruso's opinion does not cause him to change any of his prior opinions.

Counsel for Claimant argues that Dr. Caruso's opinions on Miner's condition is the most important "other" evidence of the existence of pneumoconiosis. In so arguing, counsel for Claimant states that Dr. Caruso's status as Miner's treating physician from 1994 until Miner's death entitles his opinion to controlling weight. He argued that Dr. Caruso, who is board-certified in internal medicine, diagnosed pneumoconiosis after extensive testing. Counsel for Claimant found Dr. Sundaram's January 30, 1998 bronchoscopy and biopsy report to be important, arguing that Dr. Sundaram explicitly ruled out carcinoma, tuberculosis, and Aspergillus after performing the bronchoscopy and biopsy. Counsel for Claimant argues that the report of Dr. Meredith's pathology report from Dr. Sundaram's bronchoscopy and biopsy confirms Dr. Sundaram's diagnosis.

Counsel for Employer argued that Drs. Caffrey, Naeye[6], and several other hospital pathologists reviewed the biopsy evidence, and none found any evidence of pneumoconiosis or any disease related to coal dust exposure. Rather, counsel for Employer argued that the biopsy evidence reveals various infections. With regard to Dr. Caruso's opinions, counsel for Employer asserts that they are not reasoned or supported because Dr. Caruso's diagnosis of pneumoconiosis and Caplan's syndrome are not supported by the biopsy evidence, as well as the other evidence of record. Furthermore, counsel for Employer argues that Dr. Caruso's treatment relationship did not place him at an advantage over reviewing physicians because: 1). there are no treatment notes showing the frequency and duration of his treatment of Miner; 2). there is no explanation of what he treated Miner for; 3). Dr. Caruso relied on objective testing performed by consulting

[6]Upon inspection, I have not located any report from Dr. Naeye in the evidentiary record.

physicians; and 4). Dr. Caruso repeatedly referred Miner to other doctors, so it is not rational to think that Dr. Caruso's observation or treatment placed Dr. Caruso at any advantage.

I find that the biopsy evidence does not establish the existence of pneumoconiosis. Rather, the biopsy evidence shows that Miner suffered from an Aspergillus infection in his lungs, and possibly even a bacterial infection. The biopsy evidence rules out the diagnoses of tuberculosis, histoplasmosis, or a malignancy.

Miner underwent at least five bronchoscopes and four biopsies between 1994 and 1998. After a bronchoscopy in 1994, Dr. Sundaram opined that the findings would suggest an infection origin with tuberculosis to be excluded. Dr. Whaley, who conducted a CT guided needle biopsy a few days after Dr. Sundaram's biopsy, identified an obstructive lung disease and cavitary infiltrate. Dr. Whaley suggested that the source of the obstructive airways disease was a granulomatous or infectious process, with the infiltrate secondarily involved with a fungal disease. Dr. Bensema reviewed Dr. Whaley's biopsy samples and ruled out the presence of a granuloma or a malignancy. Dr. Earle commented that the biopsies and washings were negative for tumor or infectious agents such as tuberculosis or histoplasmosis. Miner underwent another bronchoscopy in July of 1994. Microbiology reports found the specimens to contain three types of fungus, including aspergillus species. The specimens were negative for any malignancies. Dr. Sundaram performed a biopsy on Miner in August of 1996, arriving at a final diagnosis of aspergillus infection. The most recent biopsy was performed on January 30, 1998, just 7 days before Miner died. Neither Dr. Meredith's evaluation of the bronchial lavage cells, nor Dr. Anderson's evaluation of Miner's sputum sample revealed evidence of pneumoconiosis. Dr. Caruso commented that the only thing revealed from the bronchoscopy was the presence of Pseudomonas aerogenous. Dr. Boswell, who performed the biopsy, identified hemorrhaging, necrosis, and inflammation, but he did not diagnose the existence of pneumoconiosis. Drs. Caffrey and Kleinerman, who are board-certified pathologists, reviewed the biopsy slides from 1996 and 1998, finding that there was no evidence of pneumoconiosis. Drs. Branscomb and Fino also reviewed the pathological reports from the biopsies and bronchoscopes, and found no evidence of pneumoconiosis. Specifically, Dr. Caffrey stated that he did not detect any macules, anthracotic pigment, or fibrosis. Rather, Dr. Caffrey found that Miner's biopsy results showed that Miner was suffering from a fungal infection, Aspergillus. Since tuberculosis and histoplasmosis had never been definitively diagnosed, Dr. Caffrey opined that Miner had been suffering from Aspergillus all along.

The biopsy evidence conclusively establishes that Miner suffers from an Aspergillus infection in his lungs. An Aspergillus infection is not a chronic disease of the lung arising out of coal mine employment. There is no pathology report or consultative review of biopsy evidence that diagnoses the existence of pneumoconiosis. The biopsy taken just days before Miner died did not reveal the existence of pneumoconiosis. The biopsy evidence does not establish the existence of pneumoconiosis. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Sutherland examined Miner on November 23, 1987. He diagnosed CWP and mild restrictive ventilatory insufficiency. He interpreted a chest x-ray as positive. Additionally, he conducted a pulmonary function study and interpreted the results as revealing a mid restrictive defect and no obstructive defect. He found the results of an arterial blood gas study to be normal. Dr. Sutherland considered a smoking history of 36 pack years and a coal mine employment history of 11 years. He also documented Miner's subjective complaints of shortness of breath and a productive cough. Dr. Sutherland set forth clinical observations and findings, and there was adequate data to support his conclusions. However, he did not provide any reasoning to identify how he reached his conclusions. Therefore, I attribute a lesser degree of probative weight to Dr. Sutherland's opinion.

Dr. Broudy examined Miner in 1988 and opined that Miner did not suffer from pneumoconiosis. He conducted a complete pulmonary evaluation, including a chest x-ray, pulmonary function test, and an arterial blood gas study. Dr. Broudy interpreted the x-ray as negative. He found the arterial blood gas study to be normal, and concluded that the spirometry was within normal limits. Dr. Broudy diagnosed severe rheumatoid arthritis and right apical pleural thickening. He concluded that the results of Miner's spirometry and blood gases indicate that Miner's complaints of dyspnea are non-pulmonary in origin. Dr. Broudy reiterated those

findings and conclusions in a deposition on May 24, 1988. Drs. Lane and Fino offered consultative opinions in 1991, after reviewing Miner's medical records, that Miner did not suffer from pneumoconiosis. Their opinions are remote in time, thus I accord them a lesser degree of probative weight.

Dr. Caruso began treating and attending to Miner in 1994. The first record of treatment was from April 28, 1994, when Dr. Caruso examined Miner at the Highlands Regional Medical Center. At that point, Dr. Caruso documented a coal mine employment history of 10 years, with a history of smoking as a youth. Upon discharging Miner from the hospital on May 5, 1994, he did not diagnose the existence of pneumoconiosis, but he did diagnose the presence of complex infiltrates of the right upper lung of unknown etiology. He also diagnosed a chronic lung disease suggestive of infectious origin. In a short narrative opinion dated April 9, 1996, Dr. Caruso opined that Miner has extensive cavitary lung disease, and that Miner appears to have pneumoconiosis at this time. Dr. Caruso then examined Miner on August 6, 1996. He thoroughly documented Miner's medical history, noting that Miner has old burn-out rheumatoid disease associated with black lung pneumoconiosis and Caplan's syndrome, very long standing fibronodular and cavitary lung disease with long standing collapse of the right upper lobe with long standing severe trachodeviation, and long standing hemoptysis. Dr. Caruso detected crackles in Miner's lungs upon physical exam. He reviewed a chest x-ray from July of 1996, finding that it showed chronic lung disease with scarring. Dr. Sundaram provided a consultative examination and bronchoscopy upon Dr. Caruso's referral. Dr. Caruso reviewed Dr. Sundaram's records, and noted that the biopsy revealed that Miner was suffering from an Aspergillus infection of the lungs. Dr. Caruso prescribed Sporanox for long-term control of Miner's aspergillus and cavitary lung disease. Dr. Caruso diagnosed pulmonary aspergillus and CWP with cavitary lung disease.

Dr. Caruso also attended to Miner during his final hospital stay from January 29, 1998 until his death on February 6, 1998. He stated that Miner's medical history was notable for rheumatoid disease, anthracosilicosis, and Caplan's syndrome. Miner complained of coughing and extreme dyspnea at rest and with exertion. Dr. Caruso reported that Miner was a retired coal miner who had a smoking history of 40 years. He examined Miner's chest and heard coarse rhonchi. His admitting diagnosis noted that Miner was known to have cavitary aspergillus, and due to Miner's presenting symptoms, he wanted to rule out a new bacterial abscess or other associated lung infections such as emphysema. He also noted that Miner had an altered immune state with the presence of rheumatoid disease, Caplan's syndrome and anthracosilicosis. His history and physical report shows that he was prescribing Sporanox and two inhalers. Dr. Caruso then had Dr. Sundaram provide a consultative examination and a lung biopsy. He stated that the biopsy cultures showed the presence of Pseudomonas aeruginosa, and that the cultures were so far negative for tuberculosis and cancer. He began to treat Miner's Pseudomonas with antibiotics. Dr. Caruso attempted to discharge Miner on February 5, 1998, at Miner's strong urging. He dictated a discharge summary, diagnosing acute Pseudomonas bronchitis, cavitary pulmonary aspergillus, COPD, Caplan's syndrome, rheumatoid disease, hypothyroidism, and malnutrition. However, Dr. Caruso was unable to discharge Miner. A chest x-ray dated February 5, 1998 showed extremely widespread diffuse pneumonia, and it was obvious to Dr. Caruso that Miner's Pseudomona pneumonia was not controlled by the antibiotics due to Miner's state of malnutrition and his weakened immune system. Miner's condition worsened and he died the following day.

Dr. Caruso dictated an expiration summary and rendered the following final diagnoses: 1). bilateral Pseudomonas pneumonia; 2). cavitary pulmonary aspergillosis; 3). COPD; 4). Caplan's syndrome; 5). hypothyroidism; 6). rheumatoid disease; 7). malnutrition and inanition; 8). Post old gastrectomy for benign disease; and 9). chronic hypoproliferative anemia.

In a hand-written opinion dated May 13, 1999, Dr. Caruso stated that he treated Miner from 1994 until 1998 for anthracosilicosis (black lung), rheumatoid disease, (sic) Kaplan's syndrome, a cavitary nodular lung disease caused by concomitant pneumoconiosis and rheumatoid disease.

Dr. Caruso, who is board-certified in internal medicine, treated and attended to Miner over the last four years of Miner's life. The only evidence of Dr. Caruso's treatment of Miner comes in the form of hospital records. While records of Miner's office visits may exist, they are not contained in the record. Initially, Dr. Caruso suspected that Miner suffered from a chronic lung disease of infectious origin. By April of 1996, Dr. Caruso had diagnosed extensive cavitary lung disease. He also though that Miner had pneumoconiosis. Upon admitting Miner to the hospital in August of 1996, he stated that Miner had a history of cavitary lung disease, as well as rheumatoid arthritis associated with CWP and Caplan's syndrome. He reviewed the results of Dr. Sundaram's examination and biopsy, leading him to diagnose the existence of an Aspergillus infection and CWP with cavitary lung disease. He began to treat Miner's Aspergillus infection and cavitary lung disease with Sporanox. By the time Dr. Caruso examined Miner in January of 1998, Dr. Caruso's admission diagnosis was rheumatoid arthritis, anthracosilicosis, and Caplan's syndrome. He again reviewed the results of another Dr. Sundaram examination and biopsy. Upon Miner's death, Dr. Caruso diagnosed the following respiratory or pulmonary conditions: 1). Pseudomonas pneumonia; 2). cavitary pulmonary aspergillus; 3). COPD; and 4). Caplan's syndrome. A little over a year later, Dr. Caruso issued a brief narrative opinion restating his final diagnoses.

Dr. Caruso treated Miner for the last four years of Miner's life. He attended to him in the hospital for durations in excess of a week. Dr. Caruso submitted Miner to a myriad of objective tests. He reviewed at least two consultative examination reports and the results of at least two lung biopsies. He also interpreted several chest x-rays. Since 1996, Dr. Caruso had diagnosed Miner as suffering from CWP and cavitary lung disease. He prescribed medication and inhalers for Miner's pulmonary condition. Dr. Caruso also considered an accurate account of Miner's smoking and coal mine employment history. I find that Dr. Caruso's opinion is documented, as there are adequate clinical findings and observations, as well as objective data to support his conclusion. However, I cannot find his opinion to be well-reasoned; he does not identify what evidence he relied upon to reach his conclusions, nor does he provide any supporting rationale. Dr. Caruso's diagnoses are in the format of a list, often dictated as part of his recitation of Miner's medical history prior to Dr. Caruso examining Miner. He does not provide any rationale to show how he arrived at his diagnoses. Since Dr. Caruso's opinions are not backed by a reasoned opinion, I accord them a lesser degree of probative weight. In so doing, I find that Dr. Caruso possessed superior and relevant information regarding Miner, based on the frequency,

nature, extent, and duration of his treatment.[7] Had Dr. Caruso's opinions been reasoned, I would have granted them controlling weight based on his status as Miner's treating physician and his board-certification in internal medicine..[8]

Dr. Earle attended to Miner while he was hospitalized during May of 1994. Upon discharging Miner, he diagnosed COPD with bilateral cavitary pulmonary infiltrates, possible tuberculosis and possible chronic histoplasmosis, even thought he last two diagnoses were not supported by the findings of the bronchoscopy he reviewed. Dr. Earle did not provide an opinion as to the etiology of the COPD, therefore, his opinion does not support a finding of legal pneumoconiosis. Examinations conducted by Drs. Rogers and Melo in May and June of 1994 suggest that Miner was suffering from tuberculosis or histoplasmosis.

Maan Younes, M.D., who is board-certified in internal medicine,[9] examined Miner on July 21, 1995, and he completed a Department of Labor Medical History and Examination for Coal Workers' Pneumoconiosis form. He diagnosed CWP by x-ray. This is merely his interpretation of a chest x-ray; it is not a narrative medical opinion. *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). However, Dr. Younes also diagnosed hemoptysis and chronic bronchitis as evidenced by chronic cough and sputum production. Regarding the etiology of Miner's hemoptysis, Dr. Younes would primarily seek to rule out a persistent inflammatory process, and secondly, he would attribute the chronic bronchitis to "occupational lung exposure." I find that Dr. Younes diagnosis of chronic bronchitis arising secondarily from "occupational lung exposure" falls within the definition of legal pneumoconiosis. Dr. Younes set forth clinical observations and findings, and he relied upon adequate data to support his reasoning. His opinion is reasoned and documented. I find that Dr. Younes' diagnosis of legal pneumoconiosis is entitled to probative weight enhanced by his board-certification in internal medicine.

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[7]In determining the weight to be accorded to a treating physician's opinion, the amended regulations at § 718.104(d) (2003) are not directly applicable because all of the medical evidence was developed prior to January 19, 2001. The regulation is instructive. *See Wolf Creek Collieries v. Director, OWCP [Stephens]*, 298 F.3d 511 (6th Cir. 2002). In pertinent part, the regulation allows for an administrative law judge to rely upon the well-reasoned and well-documented opinion of a treating physician as substantial evidence in awarding that physician's opinion controlling weight based upon four factors: (1) nature of relationship; (2) duration of relationship; (3) frequency of treatment; and (4) extent of treatment. § 718.104(d) (2002).

[8]Counsel for Employer argues that Dr. Caruso's opinions should not be granted greater weight because Dr. Caruso was not at an advantage to other physicians because he relied upon objective testing performed by other physicians and because he referred Miner to Dr. Sundaram. Such an argument misses the point. Dr. Caruso's opinion can only benefit from having additional medical data available to him- it certainly doesn't detract from the credibility or reliability of Dr. Caruso's opinion. Dr. Caruso's opinions benefitted from the numerous times he attended and treated Miner while Miner was hospitalized, in addition to the office visits that hospital records suggest existed.

[9]Upon the request of counsel for Claimant, who relied upon *Maddaleni v. Pittsburg & Midway Coal Mining Company.*, 14 B.L.R. 1-135 (1990), I take administrative notice that Dr. Younes is board-certified internal medicine, as well as being certified as a B-reader.

Dr. Sundaram examined Miner and performed a bronchoscopy on August 6, 1996 to rule out an endobronchial lesion or tuberculosis as the source of Miner's persistent pneumonic consolidation changes in his right upper lobe of his lung. His preoperative diagnosis considered the possibility of malignancy, tuberculosis, and fungal infections. His final, post-operative diagnosis was aspergillus infection. Dr. Sundaram performed a second examination and bronchoscopy on January 30, 1998. He noted that Miner had multiple problems, including rheumatoid arthritis, Caplan's syndrome, and a previously diagnosed Aspergilloma that was being treated with Sporanox. He examined Miner's lungs and detected bilateral rhonchi and scattered crepitations, as well as wheeze in both lung fields. He reviewed some of Miner's previous chest x-rays and the x-ray that was taken upon Miner's admission to the hospital on January 29, 1998, which he interpreted as consistent with COPD. Dr. Sundaram's impression before performing the bronchoscopy was progressive weight loss with dense infiltrate over both upper lobes. He sought to rule out reactivation Aspergillosis, tuberculosis, and malignancy. His impression also included rheumatoid arthritis, Caplan's syndrome, and anemia. The record does not contain Dr. Sundaram's surgical report from the biopsy nor does the record contain any record from Dr. Sundaram after the biopsy was performed.

Dr. Sundaram diagnosed an Aspergillus infection in 1996. Two years later, his impression was rheumatoid arthritis, Caplan's syndrome, and anemia. He also sought to rule out the reactivation of an Aspergillus infection, or tuberculosis or a malignancy. After reviewing chest x-rays of Miner, he interpreted them as showing COPD. Dr. Sundaram did not offer an opinion on the etiology of the COPD. He diagnosed rheumatoid arthritis, Caplan's syndrome, and anemia in 1998 by Miner's history. Dr. Sundaram does not explicitly diagnose the existence of clinical or legal pneumoconiosis. However, his records are important for determining the accuracy and reliability of the physicians who did offer an opinion on the presence or absence of pneumoconiosis.

Dr. Branscomb conducted a review of Miner's medical records and issued a consultative report on October 13, 1997. He considered a 10 year history of coal mine employment and a cigarette smoking history spanning 35 years ranging from one-half pack per day to two packs per day. He summarized Miner's medical records dating back to 1981. He noted that Dr. Younes diagnosed Caplan's syndrome, in May of 1995, which he stated is a finding of rheumatoid nodules in the lung in persons who have both pneumoconiosis and rheumatoid arthritis. However, Dr. Branscomb asserted that the nodules are typically much smaller than those described in Miner, and pneumoconiosis must be present on the x-ray to diagnose Caplan's syndrome. After reviewing numerous chest x-rays, he considered the chest x-ray evidence to be negative for the existence of pneumoconiosis. He commented that Miner has been treated for tuberculosis and fungal infections. He added that healing occurred with bilateral apical scarring. Dr. Branscomb opined that Miner does not have simple or complicated pneumoconiosis, nor does he have any disorder caused or aggravated by coal dust exposure.

Dr. Branscomb issued a short narrative interpretation on October 30, 1997 of a CT Scan of Miner's chest performed on May 3, 1994. He opined that there are no diffuse regular or irregular opacities consistent with pneumoconiosis. Except for the extensive cavitary process, he

found Miner's lungs to be well expanded and devoid of any changes suggestive of pneumoconiosis. Dr. Branscomb was deposed on February 24, 1998, and he reiterated the findings and conclusions contained in his prior reports.

Dr. Fino, who is board-certified in internal medicine and the subspecialty of internal disease, issued a consultative report on October 22, 1997 after reviewing Miner's medical records. He summarized the records and noted his prior report of October 9, 1991. He opined that Miner does not have CWP. Rather, Dr. Fino stated that the significant changes seen on x-rays are secondary to Aspergillus infection, which has not reaction to the inhalation of coal dust. Dr. Fino concluded that there is insufficient objective medical evidence to diagnose the existence of CWP or any occupationally acquired pulmonary condition. He found that all of Miner's pulmonary insufficiency was caused by his Aspergillus infection.

Dr. Caffrey, who is board-certified in clinical and anatomical pathology, issued a consultative report on October 30, 1997. He reviewed and summarized Miner's medical records, including four pathology slides from Miner's August 6, 1996 biopsy. He found the biopsy to be positive for Aspergillus infection and absent of any findings of CWP. He considered a 12 year history of coal mining and a smoking history of one-half pack per day for 35 years, which ended in 1987. Dr. Caffrey concluded that he could not make a diagnosis of CWP or any other occupational pneumoconiosis based on Miner's records. He noted that Miner suffered from rheumatoid arthritis. He cited to medical literature to define Aspergillosis as a chronic progressive and destructive pulmonary infection in mildly compromised patients clinically resembling tuberculosis or histoplasmosis that can develop in immuno-suppressed patients. He noted that Miner had been suspected of having tuberculosis or histoplasmosis, but these two diagnoses were never confirmed. Dr. Caffrey opined that Miner developed Aspergillosis secondary to his therapy for rheumatoid arthritis. He specifically disagreed with Dr. Younes' diagnosis of Caplan's syndrome. He stated that rheumatoid arthritis is a systemic disease with five major manifestations, one of which is Caplan's syndrome. He noted that Caplan's syndrome was originally described in 1953 as a characteristic chest radiographic appearance in coal workers with rheumatoid arthritis. However, Dr. Caffrey stated that none of the radiologists have described the characteristic changes of Caplan's syndrome. Dr. Caffrey allowed that Miner may have rheumatoid pathology of the lung, and he concluded that Miner has pulmonary Aspergillosis and emphysema due to smoking. He concluded that Miner does not have pulmonary pathology that can be demonstrated due to his coal mine employment.

Dr. Caffrey issued a supplemental consultative report on April 28, 1999, after reviewing additional medical records. The additional medical records that Dr. Caffrey reviewed and summarized included the pathology slides from Miner's January 30, 1998 biopsy. He found the slides to show Aspergillus infection. He did not detect any anthracotic pigment. Again, Dr. Caffrey found that he could not diagnose the existence of CWP. He pointed out Miner's brief length of above-ground coal mine employment and significant smoking history. Dr. Caffrey concluded that Miner's rheumatoid disease, Caplan's syndrome, Pseudomonas pneumonia, and pulmonary aspergillosis were definitely not caused by his employment in coal mining. Specifically, he stated that Caplan's syndrome is the result of rheumatoid disease.

On May 2, 1999, Dr. Branscomb issued a supplemental consultative report after reviewing additional medical records. He found that the medical records documented a long history of severe chronic rheumatoid arthritis with severe gastrointestinal problems, as well as an apical process with pleural involvement, scarring, cavitation, and proved aspergillus fungus infection. He commented that the additional medical records do not contain any new information to attribute any disease to coal dust exposure, although he notes that Dr. Caruso continues to list Caplan's syndrome. Dr. Branscomb opined that there is no reasonable basis for diagnosing Caplan's syndrome, because with that disorder there is always clearly established x-ray evidence of pneumoconiosis. He added that Caplan's syndrome produces opacities generally resembling progressive massive fibrosis. Dr. Branscomb then stated that the areas of fibrosis in Miner's lungs do not suggest progressive massive fibrosis, but they are suggestive of a granulomatous process. Moreover, Dr. Branscomb noted that the opacities in Miner's lungs do not correspond with a diagnosis of Caplan's syndrome because they do not appear peripherally and they did not appear simultaneously with the onset of Miner's rheumatoid arthritis.

Dr. Branscomb set forth clinical observations and findings, and he relied upon adequate data to support his reasoning. His opinion is reasoned and documented. I find that Dr. Branscomb's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

On May 7, 1999, Dr. Caffrey was deposed. He reiterated the findings and conclusions contained in his previous reports. Dr. Caffrey testified that some physicians considered diagnoses of tuberculosis, histoplasmosis, and Caplan's syndrome. He defined Caplan's syndrome as rheumatoid nodules in individuals with pneumoconiosis. Then Dr. Caffrey stated, "but certainly we have only objective evidence of what these biopsies showed and I think that instead of TB or histoplasmosis like most of them thought, I think the man most likely had these nodules in his lungs which were full of Aspergillus organisms . . . So I think that all along they probably misinterpreted what they were seeing." Dr. Caffrey added that Miner's treatment for rheumatoid arthritis dating back to the late 1970's weakened his immune system, leaving Miner susceptible to the Aspergillus infection that he developed. He concluded that this had nothing to do with his coal mine employment. Dr. Caffrey set forth clinical observations and findings, and he relied upon adequate data to support his reasoning. His opinion is reasoned and documented. I find that Dr. Caffrey's opinion is entitled to probative weight enhanced by his credentials as a board-certified pathologist.

On May 9, 1999, Dr. Fino issued a supplemental consultative report. He reviewed and summarized additional medical records and his five previous reports. His review of the additional records did not change his prior opinion that there is no evidence of CWP. Dr. Fino also opined that there is no evidence of Caplan's syndrome, which is due to rheumatoid arthritis. Rather, Dr. Fino stated that Miner had very significant lung infections due to bacteria and fungus. Dr. Fino followed up this supplemental report with another report dated June 14, 1999, wherein he reviews Dr. Caruso's May 13, 1999 letter. He stated that his review of Dr. Caruso's letter does not cause him to change any of his opinions. Dr. Fino set forth clinical observations and findings, and he relied upon adequate data to support his reasoning. His opinion is reasoned and documented. I

find that Dr. Fino's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist. However, I note that his opinion offered very little reasoning and was not very far away from being a summary opinion.

On May 18, 1999, Jerome Kleinerman, M.D., who is board-certified in clinical and anatomical pathology, issued a consultative report after reviewing and summarizing Miner's medical records. He considered a 10-12 year history of coal mine employment and a smoking history of on pack daily for 37 years. He found Miner's medical history to be remarkable for severe rheumatoid arthritis, peptic ulcer disease, chronic anemia, and Caplan's syndrome. He noted that Miner had been treated for tuberculosis, histoplasmosis, and pulmonary aspergillosis after he developed a cavitary lung disease. Dr. Kleinerman provided an extensive summary of Miner's medical records, including reviews of pathology slides from Miner's 1996 and 1998 biopsies. He concluded, based on his review of the medical evidence, that Miner has no objective evidence of CWP. Dr. Kleinerman set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Kleinerman's opinion is entitled to probative weight enhanced by his credentials as a board-certified pathologist.

The narrative medical evidence demonstrates that Miner suffered from severe rheumatoid arthritis for almost 20 years. Dr. Caffrey and other consulting physicians opined that treatment for rheumatoid arthritis weakened his immune system, leaving him more susceptible to bacterial and fungal infections. The hospital records from 1994 through 1998, as well as the consultative opinions, clearly shows that Miner developed a cavitary lung disease as early as 1994 that was caused by an Aspergillus fungal infection. By January of 1998, Miner had also developed a Pseudomonas bacterial infection in his lungs. During those four years, Dr. Younes, Caruso, and Sundaram diagnosed Miner as suffering from Caplan's syndrome, which is the manifestation of rheumatoid nodules in the lungs of individuals with CWP. Dr. Younes was the fist to diagnose Caplan's syndrome, but he didn't provide any supporting rationale. Drs. Caruso and Sundaram appear to diagnose Caplan's syndrome by history, or they also failed to provide any supporting rationale. Drs. Branscomb, Caffrey, and Fino argued that Miner did not suffer from Caplan's syndrome because he did not have chest x-ray evidence of the syndrome, the syndrome did not appear at the same time Miner's arthritis did, and because Miner did not exhibit the opacities characteristic of Caplan's syndrome. Dr. Kleinerman noted that Miner's history was remarkable for Caplan's syndrome, but he did not discuss it any further before finding that Miner had no objective evidence of pneumoconiosis. Since Drs. Branscomb, Caffrey, and Fino provided a better rationale for stating that Caplan's syndrome was not present, in addition to their superior credentials, I find that Miner did not suffer from Caplan's syndrome.[10]

[10]Even if Miner did suffer from Caplan's syndrome, based on the medical evidence contained in this record, it would not constitute a finding of legal pneumoconiosis. Drs. Younes, Caruso, and Sundaram did not discuss the etiology of Caplan's syndrome. The consulting physicians defined Caplan's syndrome as the presence of rheumatoid nodules in the lungs of coal miner's suffering from pneumoconiosis. These physicians did not identify Caplan's syndrome as a chronic dust disease of the lung arising out of coal mine employment. Therefore, the record does not establish that Caplan's syndrome meets the definition of legal or clinical pneumoconiosis.

In 1987 Dr. Sutherland found that Miner suffered from CWP and a mild restrictive defect arising out of his coal mine employment. Dr. Younes opined that Miner suffered from CWP in 1995. However, Drs. Branscomb, Caffrey, Fino, and Kleinerman reviewed a more recent and extensive set of medical records than Drs. Sutherland or Younes did. In fact, the physicians who did not find that existence of pneumoconiosis reviewed the results of biopsy evidence from 1996 and 1998 that Drs. Sutherland and Younes did not. Miner also had an extensive smoking history, which Drs. Branscomb and Caffrey commented affected his pulmonary condition. Drs. Sutherland and Younes were aware of Miner's smoking history, but did not evaluate its effect on Miner's pulmonary condition. Dr. Caruso found that Miner's history was remarkable for anthracosilicosis, but he did not provide any supporting rationale to show how he reached that opinion. Based on the better-reasoned and documented opinions, as well as the superior credentials of Drs. Branscomb, Caffrey, Fino, and Kleinerman, I find that the narrative medical opinion evidence does not establish that Miner suffered from pneumoconiosis. Therefore, I find that Claimant has not established the existence of pneumoconiosis under subsection (a)(4).

Claimant has failed to demonstrate the existence of pneumoconiosis under any applicable subsection of § 718.202(a). Therefore, I find that Miner did not suffer from pneumoconiosis at the time of his death.

Survivor's Claim

Mrs. Endicott filed her survivor's claim on May 8, 1998. Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). The Act provides that benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. § 718.205(a). In order to receive benefits, the claimant must prove that:

1). The miner had pneumoconiosis;

2). The miner's pneumoconiosis arose out of coal mine employment; and

3). The miner's death was due to pneumoconiosis.

§§ 718.205(a). Failure to establish any of these elements by a preponderance of the evidence precludes entitlement. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

The record does not contain any autopsy report. Thus, all of the evidence considered in the living miner's claim would be the same evidence Claimant would rely upon to establish the existence of pneumoconiosis in her application for survivor benefits. I found the evidence in the living miner's claim to be insufficient to establish the existence of pneumoconiosis. Therefore, I find that Claimant cannot establish the existence of pneumoconiosis in her claim for survivor's benefits.

Entitlement

The Claimant, Ruth Endicott, has failed to prove that Auxier Endicott was totally disabled due to pneumoconiosis arising out of his coal mine employment and that Auxier Endicott's death was due to pneumoconiosis by a preponderance of the evidence. Therefore, Mrs. Endicott is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Auxier and Ruth Endicott for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**